KIIT WORLD SCHOOL

SCHOOL HEALTH RECORD

Name of student	:……	Gender	:……	Paste picture in School Uniform **with scarf** with Maroon Background
Date of birth	:……	Blood Group	:……	
Father's Name	:……	Mother's Name	:……	
Phone (Office)	:……	Phone (Office)	:……	
Phone (Res)	:……	Phone (Res)	:……	
Phone (Mobile)	:……	Phone (Mobile)	:……	
Email id	:……	Email id	:……	
Address:				

In case of emergency, please contact:
Name :……Relation with student:……At Mobile No……..

VACCINATIONS

Immunization	Age Recommended	Due Date	Done Date
BCG	0 – 1 Month		
Hepatitis B	At Birth		
	1 Month		
	6 Months		
DPT	2 Months		
	3 Months		
	4 Months		
H1B	2 Months		
	3 Months		
	4 Months		
Oral Polio	At Birth		
	1 Month		
	2 Months		
	3 Months		
	4 Months		
Measles	9 Months		
MMR	16 Months		
DPT + OPV + H1B	18 Months		
Typhoid	2 Years		
Hepatitis A(2 Doses)	2 Years		
Chicken Pox	After age 1 year		
DT-OPA	4 ½ Years		

BOOSTER DOSES

Typhoid (every 3 years)			
TT (every 5 years)			
Other Vaccines			

Signature of father: …… Signature of Mother:……..

ALLERGY TO ANY FOOD, ADHESIVE TAPE, BEE STING

Allergies	What happened	How severe	Medication taken at the time of allergy

KIIT WORLD SCHOOL

HPE ASSESSMENT – MEDICAL RECORD

To be certified by a registered medical practitioner

STUDENT INFORMATION

Assessment Date:……

Name of student:…… Grade and Section:…….

Medical Officer:…… Blood Group:…….

Body Measurement		Circumference		Health Status	
Height (cm)	Weight (kg)	Hip (cm)	Waist (cm)	Pulse (Rate)	Blood Pressure(mmHg)

Posture Evaluation

Head Forward	Sunken Chest	Round Shoulder	Kyphosis	Lordosis	Abdominal	Ptosis
Body Lean	**Tilted Head**	**Shoulders uneven**	**Scoliosis**	**Flat Feet**	**Knock Knees**	**Bow Leg**

Vision (RE/LE)	Squint	Conjucavita	Ears (Left/Right)	Cornea	Ear Left	Ear Right	Teeth Occlusion (Caries/Tonsils/Gums)

Clinical Examination	Normal	Recommendations
Head/Neck		
Abdomen		
Surgery		
Serious Illness		
Nails		
Skin		

Summary of current health condition

……

……

- He/She is fit to participate in age specific physical activity with precaution …….
- Fit to participate in age specific physical activity with precaution…….
- Should not participate in competitive sport……..

Name of Doctor ……. Signature of doctor……

PARENTS INFORMATION

Mother's Name	Year of Birth	Weight (kg)	Height (cm)	Blood Group	Aadhar Card No.	Mother's Phone No.
Father's Name	**Year of Birth**	**Weight (kg)**	**Height (cm)**	**Blood Group**	**Aadhar Card No.**	**Father's Phone No.**

CWSN (Child with Special Needs), Specify _____

Signature of parents/ guardian Date: